Social Stigma and Psychiatric Disorder

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Statement of the problem

The social stigma associated with psychiatric disorder is often a reason cited for the delay or avoidance of treatment. It is thus of concern to mental health practitioners caring and advocating for ill individuals. As a cultural phenomenon, stigma also poses challenges for those who manage treatment settings and policy makers who must deal with the image of those labeled as mentally ill. My dissertation was a correlational study with a panel design which examined, over a four-month time span, the personal experiences and perceptions of stigma by psychiatric patients receiving medical and psychosocial treatments under the auspices of federally funded studies of unipolar (UP) and bipolar (BP) affective disorders.

The word "stigma" is defined as a mark, and originally referenced a physical mark. Although not a pejorative term in its Greek origin, it has become associated with its later Latin usage in referencing physical identifying marks inflicted on criminals. As the term is used today, stigma is not a physical mark, but a metaphorical one, referring to a blemish or flaw of character. The negative connotation has endured, and individuals whose behavior is not understood are often thought of as less worthy, possibly dangerous, and are thus socially, rather than physically, stigmatized.

Evidence of social stigmatization of psychiatric disorder in our culture abound. Hyler et al. (1991) and Signorielli (1989) quantified the disproportionate negative portrayals of the psychiatric patient on television and in movies. Equally telling is the lack of positive references to psychiatric patients. We never see stories of a "mental patient" who, for example, rescued three children from their burning home. Stigma is further evidenced by communities which fight to exclude group homes (The Robert Wood Johnson Foundation, 1990), and in studies providing data that psychiatric patients have lower status jobs and lower income (Link, 1982); receive harsher treatment in the criminal justice system (Walsh, 1990); and that they disproportionately represent the homeless.

Hypotheses

Social devaluation and discrimination as a result of the stigma of a psychiatric disorder can only be said to occur if other people actually know of the disorder; after all, there is no physical mark. Thomas Scheff's theory of labeling (1984) provided the framework within which to quantify the degree to which others knew of the potentially stigmatizing condition and to formulate hypotheses to predict its effect. There were four hypotheses based on three of the propositions of labeling theory. The first was that higher

social visibility of a psychiatric episode would be associated with greater acceptance of a label of a psychiatric disorder. The second hypothesis was that higher social visibility of a psychiatric episode would result in immediate social distancing and, as formulated in the third hypothesis, would continue over four months time. Last, it was hypothesized that an individual's fear of discrimination as a result of psychiatric disorder would be associated with social distancing.

There were also exploratory research questions. Differences between the diagnostic and gender groups on independent and dependent variables were examined, as were differences between these grouping variables on the hypothesized relationships. Aside from theoretical interest in comparing these groups, the exploratory analyses were of particular concern given two methodologic limitations of the study: 1) the UP protocol was a study of women only, thus there are no UP males in the study; and 2) the BP group included patients in manic, depressed, or mixed states, thus making this an affectively heterogeneous group under the BP diagnostic umbrella.

Methodology

A semi-structured interview instrument had been developed by the author, and previously tested with different clinic patients, for the purpose of quantifying two indices of the social visibility of the UP and BP disorders. These visibility measures constituted the primary independent variables of the study. The interview process was as follows: During the interview, the author and patient first reviewed both the symptoms and features of illness as listed in DSM-IV. Next, the patient was asked to choose the four most problematic symptoms and we reviewed whether others came to be aware of those symptoms. This was done by methodical review of four social network components (friends and neighbors; other community contacts; boss; and co-workers). The patient estimated whether most, some, few or none of the individuals in each network component had come to be aware of each of the four symptoms.

Later on, both visibility indices were derived from the interview. The rationale for using two indices was to avoid the exclusion of potential sources of social visibility. The first index was a simple count of the potentially visible features exhibited during the presenting episode of illness (9 features of depression, 11 of mania). This index did not require insight on the part of the patient and sometimes used clinical notes and history to complete. It was also a measure that could be derived even if a patient had very few social contacts.

The social network data which comprised the second index of visibility were averaged, and the final visibility scores ranged from 0 (no one knew of the four symptoms) to 3 (most people knew). Ultimately, the four social network components were combined for one overall "social visibility" score. The value of this second index was that it directly tapped the patients' own experiences or perceptions of social distancing. This index,

unlike the first, required a certain amount of insight in order to identify the potentially stigmatizing symptoms.

The author had also developed a questionnaire, pre-tested with 20 patients not included in this study, which produced reliable scales measuring the dependent variables of label acceptance and of social distancing (withdrawal and rejection), as well as the independent variable of expectation of stigmatizing attitudes in others. The questionnaire items which focused on label acceptance referenced two possible labels: a generic "mental illness" label and a diagnostic specific label (depression or manic-depression). Although not part of the formulated hypotheses, this exploration reflected concerns about the powerful effects of terminology (Clausen, 1981; Mechanic et al., 1994) and permitted later comparison of the acceptability those two labels. The questionnaire was completed by each patient on three occasions over a total of four months: the day of the interview, two months later and again in two months.

Results

Sixty-one patients participated in the study: 29 with UP disorder and 32 with BP disorder. The 29 UPs were female, as were 18 BPs, while 14 in the BP group were male. 58 were Caucasian with an average of 15 years of education. All patients had prior episodes of illness (8 prior of unipolar depression and bipolar mania; 18 prior of bipolar depression). 36% of the patients were married or co-habitating, 33% were divorced or widowed, and the remaining were never married. 68% of the patients were employed either full- or part-time. Mean and median incomes ranged from $600 to $700 per month, while the modal income category was $1001-$1500/month. These life style data remained essentially unchanged during the four month span of the study.

Mean social visibility scores were low: 4.93 ± 1.71 for the first index (possible range 0-20); and $.57 \pm .43$ for the second index (possible range 0-3). Statistical analyses provided little support for the hypotheses predicting an effect of visibility. When analyzed using Pearson correlation coefficients, the two indices of visibility were not significantly correlated with either label acceptance (hypothesis #1) or with initial social distancing measures (hypothesis #2). It is noteworthy that patients found their diagnostic-specific label (depressed or manic-depressed) as acceptable while they were neutral or uncertain about the "mental illness" label.

Testing of hypothesis #3, that higher visibility would be associated with distancing over time, employed a mixed-model ANOVA, with one grouping variable (high or low visibility) and one repeated measures variable (social withdrawal or rejection). There was no statistical support for the hypothesized main effect of visibility on either distancing mode, nor was there an interaction effect of visibility and time. However, there was an unanticipated main effect of time. Irrespective of high or low social visibility of symptoms, there was a significant lessening over the four months of both social withdrawal and perception of social rejection. For the first index of visibility,

$F(2,104)=8.15$, $p<.001$ for withdrawal and $F(2,102)=3.01$, $p<.05$ for rejection. For the second index, $F(2,108)=7.53$, $p<.001$ for withdrawal and social rejection approached significance, $F(2,106)=2.86$, $p<.06$.

Testing of the fourth hypothesis employed a Spearman rank order coefficient and provided partial support for the prediction. At each of the three time points, there was a statistically significant relationship between the expectation of stigmatization from a diagnostic label with a perception of social rejection (rho=.42,.33, and .30, with respective p values <.001,.01.,.02). There were no significant findings when either social withdrawal or the mental illness label were included in analyses.

Exploratory t-test analyses revealed no differences in mean scores between the UPs and BPs on the independent or dependent variables. Likewise, t-tests comparing mean scores between males and females revealed no differences except at time one, when the females reported significantly higher social withdrawal than the males ($t=2.10$, $p<.04$).

The change in social withdrawal over time was moderated by diagnosis. A significant interaction effect of diagnosis by time [$F(2,110)=5.77$, $p<.004$] revealed lowering social withdrawal by the UP group and an unchanging level of social withdrawal by the BP group. This was further explored using a mixed-model ANOVA comparing the UP group (all females) with the female BPs. There was a significant main effect of time, indicating overall lessening of withdrawal [$F(2,82)=10.89$, $p<.001$], but no main effect of diagnosis. This suggests that the trend toward lower social withdrawal over time is a function of gender.

Although the subgroups were quite small, a preliminary glance at the males indicated that the BPs in a manic or mixed state (n=8) increased in social withdrawal over time (which likely reflected a lessening of the manic state), but those males in a depressed state (n=6) did not reproduce the pattern of lowering social withdrawal over time. In contrast, the depressed female BPs decreased in social withdrawal over the three time points.

Finally, earlier partial support for the fourth hypothesis was not replicated with the UP group, but was significant for the BP group as a whole at each time point (Pearson r coefficients significant at $p<.01,.02,.04$, respectively). When the BP group was separated by gender, only the female BPs replicated this finding, indicating an association between an expectation of stigmatization and the perception of social rejection at times one ($r=.73$, $p<.001$) and two ($r=.59$, $p<.02$).

Implications for Social Work Practice

Before discussing implications for practice, the nature of patients' social networks merits brief mention. The 61 patients in this study had, on average, at least 8 prior episodes of their illness. This lead to some speculation as to whether the social networks referenced in this study were of the same composition as those at the time of the first episode of illness; that is, greater social distancing might have been reported by patients if they had been interviewed at the time of their first episode. The current social networks may reflect the outcome of a selection process to include only those who could tolerate exacerbations of psychiatric illnesses.

With that in mind, some implications for practice as well as policy can be gleaned from findings regarding the social visibility construct. The first index addressed those features of illness which are not under the direct control of the individual but are, instead, manifestations of an as yet uncontrolled disease process. Social visibility was not, however, all-or-nothing, and the mean visibility score was well within the low to mid-range. This may be useful information to patients who fear that their disturbed thoughts or actions are visible to the world at large.

The low mean score of the second visibility index suggests a fear of discussing one's psychiatric difficulties and thus possibly a fear of stigmatization. The perceived social rejection associated with the expectation of stigmatization suggests that such a fear may have a negative effect on one's social relationships for a while, a more relevant issue for BP women than for UP women. This may be useful data for the clinical social worker as it suggests different clinical concerns for these diagnostic subgroups of women. At the policy level, while national mental health advocacy groups actively lobby to destigmatize psychiatric disorder, the fear that patients have of that stigma may itself be a facet of campaigns that merits attention or acknowledgment.

The decreasing social withdrawal by both UP and BP women suggests that, even though they may not be sharing their difficulties with others, these women nonetheless did not lose contact with their social networks. This is noteworthy for clinicians because it suggests that a lack of communication with other women about symptomatology does not necessarily reflect a lack of meaningful social support. Also, the perception of rejection associated with the fear of stigma had diminished for the BP females after four months time, suggesting that any social difficulties they had experienced eventually eased. Last, the actual social experiences of these women (the lowering of social withdrawal) may not have supported their apparent fear of stigmatization, and this in turn may be meaningful data for advocacy groups regarding the issue of fear.

Last, there is some concern that the BP depressed males did not decrease their social withdrawal over time as did the depressed BP and UP females, raising speculation that the social networks of males are either less supportive or less utilized, and thus perhaps not of sufficient focus in treatment. This social outcome may also suggest that

males are more indelibly stigmatized than females: the culture-at-large may be more fearful of, and thus less socially forgiving of men whose behavior is not understood. While this is highly speculative given the small number of depressed males in the study, it may be a meaningful area of clinical and future research attention.

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